

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 010416	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/25/2013
NAME OF PROVIDER OR SUPPLIER CLARE BRIDGE OF CARMEL LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 301 EXECUTIVE DR CARMEL, IN 46032		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
R 000	<p>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaint IN00120761.</p> <p>Complaint IN00120761 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey date: January 25, 2013</p> <p>Facility number: 010416 Provider number: 010416 AIM number: N/A</p> <p>Survey team: Christi Davidson, RN</p> <p>Census bed type: Residential: 59 Total: 59</p> <p>Census payor type: Other: 59 Total: 59</p> <p>Sample: 3</p> <p>Clare Bridge of Carmel, LLC was found to be in compliance with 410 IAC 16.2 in regard to the Investigation of Complaint IN00120761.</p>	R 000			

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TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

65DX11

If continuation sheet 1 of 1